DRUG & ALCOHOL FINDINGS Matrix cell

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Drug Treatment Matrix cell A4: Interventions; Psychosocial therapies

K Match counselling style to the client (2003). US trial shows that structure and directiveness are key dimensions on which therapies can be matched to client characteristics. For related discussions click here, here and here and scroll down to highlighted headings.

K Visual aids enhance counselling (2009). Developed in the USA and popularised in the UK, node-link maps are flow charts of a patient's aims and plans intended to facilitate patient-counsellor communication; in this study they helped methadone patients reduce illegal opiate use and probably also cocaine use.

K Linkage programme boosted attendance at 12-step groups but not abstinence (2012). Study in London tested the ambition to extend recovery beyond formal treatment by systematically linking patients to mutual aid groups. About 43% were being detoxified from drugs other than alcohol. Group attendance was substantially boosted but not abstinence from the primary problem drug, a pattern seen in similar US studies. See also review (2004) of how treatment services can promote mutual aid.

K Couples therapy improves the lives of both partners (2003). Established most firmly for dependent drinkers, this study showed that the benefits of systematically involving a patient's wife/partner in their treatment extends to the use of an opiate-blocking medication to sustain abstinence from heroin and allied drugs. Relative to alternative therapies, there were also improvements in family functioning and other social and legal domains. Similar story for methadone patients (2001; free source at time of writing). Note doubts over the probity of the work of lead author in both studies.

R Common core of therapy: effective relationships (American Psychological Association, 2011). Introduces reviews based on the understanding that therapeutic change is generated not only by technical interventions but by the ways clients and therapists relate. From here you can find the component reviews and the overall conclusions (2011) reached by the American Psychological Association's task force. For discussion click and scroll down to highlighted heading.

R Directiveness is a key difference between therapies (2006). Rather than specific techniques, the interpersonal style (eg, directive v. patient-led) associated with different therapies is why some work better with some clients than others. For related discussions click here, here and here and scroll down to highlighted headings.

R Reviews of trials of motivational interviewing (Cochrane review, 2011) and cognitive-behavioural therapy (2009) suggest any structured approach grounded in a coherent theory is as good as any other, a major plank in the case for prioritising the common factors shared by psychosocial interventions. For related discussions click here, here, here and here and scroll down to highlighted headings.

R Motivational starts to treatment better without the manual (2005). Findings review discovered that motivational interviewing is not always preferable to more directive approaches, and has worked best when the therapist is not constrained to a manual, no matter how expertly drafted – a conclusion confirmed by a synthesis of research findings (2005; free source at time of writing). For related discussions click here and here and scroll down to highlighted headings.

R Mindfulness meditation takes its place among addiction therapies (2009). Variants of mindfulness meditation are among the 'third wave' of behavioural therapies allying Western and Eastern traditions. This first review of their application to addiction finds them equivalent to other structured therapies; similar conclusions from a more recent review (2014). Neither could include a later trial (2014) which found mindfulness more effective than group therapy based on the 12 steps and (on some measures only) a cognitive-behavioural relapse prevention programme. For related discussion click and scroll down to highlighted heading.

R Helping each other get better (2009). Monograph from leading authority on peer-based recovery from addiction includes a chapter on the evidence for NA, AA and allied mutual support networks and treatments based on the same principles. See also a review (2004) of how treatment services can promote mutual aid and a synthesis of studies (1999) of approaches based on AA/NA's 12-steps versus alternative approaches.

R Therapeutic communities certainly work while residents stay (2012). Shortcomings in the original studies prevented

a firm conclusion on the lasting benefits of residential rehabilitation houses where residents exert mutually therapeutic influences, but during their stays substance use was significantly reduced. For related discussion related click and scroll down to highlighted heading.

R Reserve therapeutic communities for the most vulnerable patients (2013). Review specific to users of illegal drugs argues that therapeutic communities should be reserved for patients with multiple and severe problems who do not do well in outpatient treatment due to the lack of structure and supports, or due to living in areas where drugs are easily available and widely used.

R Some patients get *worse* (2005). Reminder that after psychosocial therapy up to 15% of clients end up worse than before. Some of the reasons are thought to be a weak client-therapist relationship, failing to assess how clients are doing, being confrontational or critical, low or inappropriate expectations, and lack of challenge. For discussion click and scroll down to highlighted heading.

R Can rewards and sanctions displace counselling and therapy? (2016). Effectiveness Bank hot topics on contingency management (2016) and drug testing allied with sanctions (2016) ask whether we can dispense with counselling and therapy and just punish people or deprive them of rewards when they use substances in ways they and/or we would rather they didn't, and reward them when they behave as we and/or they would wish.

R How lasting are the effects of offering prizes for abstinence? (2014). Free source at time of writing. Systematically giving substance use patients a chance to win valuable prizes if they test abstinent offers a lower-cost alternative to other 'contingency management' systems which provide rewards each time. Research synthesis shows that in the short term it works, but effects soon fade.

R Psychosocial interventions for stimulant use problems (Cochrane review, 2016). Amalgamation of results of randomised trials of psychosocial therapies for problem use of cocaine, amphetamines or other stimulants, finds them better than basic support but no better than usual treatment, and there was insufficient evidence to distinguish between different therapies.

G NICE-recommended psychosocial interventions ([UK] National Institute for Health and Care Excellence [NICE], 2007). UK's official health advisory body recommends contingency management and behavioural couples therapy. Implementation advice below. For related discussions click here and here and scroll down to highlighted headings.

G Implementing NICE-recommended psychosocial interventions ([English] National Treatment Agency for Substance Misuse, 2010). Report from the British Psychological Society on how to implement recommendations in guidance above; includes protocols for conducting the main psychosocial therapies. For discussion click and scroll down to highlighted heading.

G Expert US consensus on group therapy ([US] Substance Abuse and Mental Health Services Administration, 2005). Guidance on the different types of groups, how to organise and lead them, desirable staff attributes, and staff training and supervision.

G Principles rather than programmes for how to relate to clients and what to say/do (2006). Free source at time of writing. Based on reviews commissioned by the American Psychological Association. Argues that the principles it extracts from research "provide a more research-informed and potentially effective approach to treatment than either the application of a one-size-fits-all standard treatment protocol or the use of idiosyncratically selected interventions". For discussion click and scroll down to highlighted heading.

MORE Search for all relevant Effectiveness Bank analyses or for sub-topics go to the subject search page or hot topics on contingency management, residential rehabilitation, motivational interviewing, 12-step mutual aid and counselling in methadone treatment.

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What is this cell about? Every treatment involves direct or indirect human interaction, but this cell is about treatments in which interaction is *intended* to be the main active ingredient – 'psychosocial', or more colloquially, 'talking' therapies. They attempt to change how the patient behaves directly by 'shaping' it through rewards and sanctions, or via their beliefs and attitudes, how they relate to others, and how others relate to them. For an 'alcoholic' or 'addict', simply being cared for and valued in a healing context focused on your aspirations, needs and welfare may be (following seminal therapist Jerome Frank's formulation) a re-moralising experience, but usually there are also specific techniques or strategies derived from various understandings of how dependence arises and how it can be reversed.

Interventions vary in type, intensity and duration, ranging from brief advice and counselling to extended therapies based on psychological theories, and all-embracing residential communities where clients stay for several months. Techniques and strategies might include: rewards and punishments contingent on client behaviour (contingency management); leading the client to see their substance use as contrary to desired self-images or objectives (as in motivational interviewing); harnessing social influences (as in group and family therapies and community living arrangements); identifying with the client what triggers their undesired substance use and training them how to manage or avoid those triggers (as in cognitive-behavioural therapies); ways to manage thoughts and moods which otherwise might precipitate relapse (as in mindfulness approaches); and more practical elements, such as those intended to upgrade the patient's employability.

Whether based on theory and research, religion, morals or experience, belief systems underlie these approaches. Most prominent in the research are the 12 steps of Alcoholics Anonymous, Narcotics Anonymous and allied fellowships, and the understanding that addiction can be learnt and unlearnt, which underpins major psychological therapies, including those recommended by the UK's official health advisory body, the National Institute for Health and Care Excellence (NICE).

Where should I start? This cell is partly about the relative merits of different psychosocial therapies, but also about the therapeutic properties they share and how such 'common factors' can be made more potent. Since these have become seen as the major influences in the treatment of addiction, let's start there.

Discussed also in cell A2 of the Alcohol Treatment Matrix, these cut across the supposedly distinct mechanisms keyed into by approaches at opposite theoretical poles such as cognitive-behavioural therapy and psychoanalysis, turning the spotlight instead on non-specific influences. Thought to be among these (▸ panel right) are a confiding, emotionally charged relationship with a helping person, a setting in which psychological healing is expected, a plausible explanation for the patient's symptoms, and a ritual or procedure for resolving them – any ritual will do, as long as in that culture and for that patient it makes sense of the patient's difficulties and signposts a convincing and feasible way out (1 2).

Across psychotherapy, shift of attention to these factors has partly been prompted by so-called 'Dodo bird' findings (an Alice-in-Wonderland reference ▸ illustration) derived from that different therapies have very similar effects, for which in this cell we find some evidence (1 2

What are the common factors?

The common factors model "focuses on factors thought necessary and sufficient for change:
- an emotionally charged bond between the therapist and patient;
- a confiding healing setting in which therapy takes place;
- a therapist who provides a psychologically derived and culturally embedded explanation for emotional distress;
- an explanation that is adaptive (ie, provides viable and believable options for overcoming specific difficulties) and is accepted by the patient; and
- a set of procedures or rituals engaged by the patient and therapist that leads the patient to enact something that is

3) in relation to drug dependence in particular. Further evidence of the centrality of common factors has come from findings that with problem drinkers, therapies stripped down to the common factors can work as well as supposedly more active approaches (1 2), and that when therapies do vary in effectiveness this may not be due to their purportedly distinct active ingredients, but to variations in the degree to which they engage certain common-factor type influences.

positive, helpful, or adaptive."

A symbolically and practically significant turning point was the refocusing on common factors by the American Psychological Association (APA) via their appropriately named Interdivisional Task Force. Updating work from 1999, in 2011 the task force analysed the literature to identify what constitutes an effective relationship between therapist and patient. Take a look at our account of the introductory article listed above. From there you can access the component reviews and the task force's overall conclusions (listed above).

In *Alice in Wonderland* the Dodo bird declared, "Everybody has won and all must have prizes."

Highlighted study One of the most consistent findings on matching therapists with clients is that directive therapists risk a backlash from clients with a short fuse or who resist other people's attempts to lead the interaction. Conversely, calmer patients or those who welcome direction thrive when given more of a lead. In a review listed above we found that applies also to substance use clients. The finding were about the characteristics of therap*ists*, but therap*ies* too differ in the directiveness they require or encourage. What if the *same* therapists implemented these different approaches; would the same matching finding emerge?

That question was answered in the affirmative by the results of a US study at a clinic where cocaine was the dominant drug problem. Read our account and you will see that patients were randomly allocated to therapies designed in some ways to be at opposite poles: one highly structured and directive; the other, less structured and non-directive, the counsellor acting primarily as a sounding board for the patient. How far patients welcomed direction was not directly assessed, but a similar variable was – 'learned helplessness'. Patients high on this dimension are likely to feel the need to be given direction, while those at the opposite pole are confident in their abilities to do the directing themselves.

Neither approach was preferable overall, but this masked different impacts on different types of clients. As expected, those characterised by learned helplessness did better when the therapy required the counsellor to take the lead, while clients who felt more in control of their lives did better when the less structured therapy allowed them to set the agenda. Depressed clients also did best in the structured therapy and worst when required to take the initiative, again, potentially related to their tolerance for and need for direction.

Apart from the specific findings, the study is a reminder that it would be a mistake to take an 'It doesn't matter what you do' message from reviews and studies which average outcomes from different approaches across all patients. Though the equivalence of therapies might be true on average, it is not necessarily true for each individual or for different types of patients. And it clearly does matter how you behave in the sense of having good therapeutic manners, leading to warnings (listed above) from the American Psychological Association against being confrontational, hostile, pejorative, critical, rejecting, or blaming. Note too that they also cautioned that there are no universal rules; unlike public health approaches, treatment is essentially the treatment of an *individual*. This maxim is explored further below.

Issues to consider and discuss

▸ **Research may have to package; therapy does not** The comment immediately above brings us to an important point (free source at time of writing) about research on psychosocial therapies and its links to practice. In order to pin down what caused any improvements, researchers often tightly control what is being delivered by manualising interventions and training and supervising therapists to ensure they follow the manual. But (as demonstrated by our review of motivational interviewing listed above)

though this might be the best way to do research, it is not necessarily the best way to do therapy, which has to sensitively adapt to where the patient is at in solidifying their commitment to tackle their substance use problems.

Similarly, researchers generally standardise interventions to a set schedule and time period in order to limit costs, equalise time spent with therapists in a comparison therapy, and to have a set end date from which the follow-up period can begin. Twelve weeks is a frequent compromise between a manageable research intervention and one long enough to have a fair chance of working. As a result, 12-week treatments collect an evidence base around them and become recommended practice in influential guidelines, such as those developed by the UK's official health advisory body – the National Institute for Health and Care Excellence, better known as NICE (1 2). Yet there is no reason to believe that because 12 weeks is convenient for researchers, it is also the span over which patients should be treated. Some manage well with less, others (see cell D2's bite) benefit more from longer term care.

What is happening here forms a less than virtuous circle. Research takes its ideas from practice, standardises and packages that practice, and then tests it. Via recommendations from authorities reliant mainly on research findings, practitioners may then be persuaded that the researchers' packages – now 'evidence-based' – are how they too should do therapy. Break this circle by treating research as an aid to reflecting on and developing practice, not a blueprint. This was the approach taken by authorities from the British Psychological Society when they developed their guidance (listed above) on implementing the main psychosocial therapies recommended (listed above) by NICE. The authors insisted that though their framework "draws heavily upon treatment manuals, it enables a more comprehensive approach to implementation than a manual alone can provide … It allows a degree of flexibility and adaptation at the level of the individual service user. Such flexibility may not be present in a particular manual, the development of which may instead be rooted in a specific service in a particular health care setting."

Are these always the important things to do? Start this exercise by free of charge downloading guidance listed above from the American Psychological Association .

Under the heading, "Treatment factors," on page three of the PDF file it says research "suggests that a number of specific therapeutic elements are characteristic of effective treatments". Take a critical look at these elements. They include "explicitly helping the client restructure his or her social environment in ways that support change" – or more specifically, change in the form of abstinence. There is evidence (1 2) that conducted systematically, this may help – but for users of illegal drugs, that evidence is very slim, and expectations that this would be the best approach for dependent drinkers in Britain were not realised when rigorously tested. How feasible is this kind of social restructuring for the clients you know? Do they have the resources – psychological, social and material – to replace environments, friendships, even families and intimate partners conducive to drug use, with those more conducive to non-use? Unless they can, gains from the radical social re-engineering possible in a contained environment like a residential community (review listed above) remain vulnerable on discharge.

Next element is a "focus on client motivation for change" – possibly, suggests the guidance, through 'decisional balance' exercises leading them to weigh up the pros and cons of changing their substance use. But if patients are *already* committed to change (as many will be), perhaps it is not such a good idea to encourage them to rehearse the *good* things about their substance use? On this question, read on page six (numbered 28) of a Findings review listed above our comments on the findings of three studies, two primarily of cocaine users and one of drinkers: "the puzzle is not why the least committed subjects benefited from a motivational approach (this is the expected result), but why the most committed reacted badly … Possibly the explanation is what to the patient may have seemed a backward step to re-examine the pros and cons of whether they really did want to stop using drugs or commit to treatment and aftercare, when they had already decided to do so and started the process." Also ask yourself, if focusing on client motivation is a key to effective therapy, why across relevant studies has motivational interviewing not proved (review listed above) superior to other therapies?

Next in the guidance's list of "elements … characteristic of effective treatments" we move into the territory of cognitive-behavioural therapies: "helping the client to develop awareness of repetitive patterns of thinking and behavior that perpetuate substance use … accompanied by a focus on helping the client learn alternative coping skills." If this is a key to effective therapy, why on average do cognitive-behavioural therapies do no better (review listed above) than other approaches?

Then we learn that "Effective therapies attend to the affective [emotional/mood] experiences of the client, particularly in relation to their substance use." Yet we know too that a focus on emotions can for some patients be counterproductive.

Finally, the guidance identified "strong evidence for the role of conditioning in the development and maintenance of substance use disorders," and argued that "repeated exposure to alcohol- or drug-related situations without using" can weaken these conditioned reactions and bolster the patient's confidence that they can handle such situations without using drugs. Yet for this so-called 'cue exposure' therapy, the UK's official health advisory body was unable to find (guidance listed above) a single study which met its quality criteria, leaving it, as far as NICE was concerned, without a research leg to stand on.

These points are made not to criticise the *in-general* very sensible suggestions made in the guidance, but to reinforce the point that generalisations are bound sometimes to be misleading in what is essentially an individualised response to an individual set of circumstances, never before encountered in precisely the same configuration.

▸ **Can therapy really make things *worse*?** Look back at the *Highlighted study* section and the warnings from the American Psychological Association against counsellors being confrontational or negative. Lest you think these overstated, note they are among the reasons why a substantial minority of clients actually get worse after therapy. Avoiding this risk (especially provoking resistance to change) has been embodied most explicitly in motivational interviewing. Among heavy drinkers, its credentials in this respect were seemingly confirmed in a seminal trial. Proofed against counterproductive reactions, appropriate for all levels of severity, generally as effective (review listed above) as other approaches but considerably briefer, motivational interviewing has been seen as a promising starting point for substance misuse treatment, one at least unlikely (recalling the first maxim of medicine) to do any harm.

That may be true in the absolute sense, but not in terms of (review listed above) lost opportunities to help patients who would have benefited more from another approach. Sometimes it really is best just to tell patients what they should do or otherwise break motivational interviewing's 'rules' rather than inflexibly follow the manual.

Probably the best established ways therapists can both get it right and get it wrong lie along the dimension of directiveness versus non-directiveness, explored in a Findings review listed above. They can get it wrong by trying to take charge with patients who react against being led – a clash motivational interviewing aims to avoid – but also by adopting motivational interviewing's typical, 'It's up to you,' stance with patients who need a lead. The perhaps uncomfortable truth seems to be that beyond the obvious, there are no universal rules: some people need to be led, others to lead; some told what to do, others to feel they have come to their own decisions; some need arousing, others soothing – and needs can change as therapy progresses.

> *Sometimes it really is best to tell patients what they should do*

So when Britain's official health standards agency NICE advises that some forms of substance use therapy "should be based on a relevant evidence-based treatment manual," remember they mean *based* on, not prescribed in advance no matter who the patient or whatever their needs and preferences at the time.